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DIRECTIVE 189

RE: EMERGENCY RULE 20

NOTICE TO ALL HEALTH INSURANCE ISSUERS, HMOs, PPOs, MCOs, TPAs AND ANY OR ALL OTHER HEALTH ENTITIES LICENSED OR DOING BUSINESS IN LOUISIANA

RE: Interpretation and Application of Emergency Rule 20

Following the original issuance of Emergency Rule 20 on October 16, 2005 there have been numerous requests from persons affected by this action regarding the need for the Department to provide some additional guidance as to how health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities licensed or doing business in Louisiana and health care providers and/or health care professionals should apply Emergency Rule 20. Accordingly, pursuant to these requests, the Department hereby issues Directive 189. All affected persons are to conduct themselves in accordance with the purpose and intent of Emergency Rule 20 and are to be guided by the overriding principle that the insured is to be protected to the maximum extent possible.

I hereby direct health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities licensed or doing business in Louisiana, as well as health care providers and health care professionals, that Emergency Rule 20 is to be interpreted and applied as follows:

1. §3703.A includes the following provision: "The right of health insurance issuers, HMOs, PPOs and MCOs to conduct retrospective medical necessity reviews and retrospectively deny any and all claims is hereby suspended for non-elective health care services. Additionally, the right of health insurance issuers, HMOs, PPOs and MCOs to recoup or offset with regard to any and all claims for non-elective health care services is hereby suspended." This provision is to be interpreted such that this type of activity is not only "suspended" but is also prohibited for any and all claims submitted to any and all health insurance entities regulated by the Louisiana Department of Insurance for non-elective health care services that occur during the time when the State of Emergency is in effect. Thus, with regard to claims for non-elective health care services, retrospective medical necessity reviews and retrospective denials are prohibited. This prohibition shall apply to claims incurred during the State of Emergency. Any attempt to conduct retrospective medical necessity reviews or retrospectively deny such claims shall be viewed as a violation of Emergency Rule 20.

2. §3715 begins with the statement that "All laws relating to timely payment are suspended..." The intent of §3715 is that the "timely payment" provisions set forth in LSA R.S. 22: 250.31 through and including LSA R.S. 22:250.38 are "suspended" except for LSA R.S. 22:250.36. Additionally, the "timely payment" provisions set forth in LSA R.S. 22:250.51 through and including LSA R.S. 22:250.62 are "suspended" except for LSA R.S. 22:250.58.

3. Pursuant to §3717, the payment by insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities of fifty (50%) percent of the contracted reimbursement rate or non-participating rate is to be considered full and final payment for covered health care services rendered to those insureds/persons defined under §3701. §3717 recognizes that health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities are making payments on behalf of insureds/persons to health care providers and/or health care professionals without having received any premium for the underlying policy. Accordingly, health care providers and/or health care professionals who accept the payment set forth in §3717.A(1) or (2) shall have legally released the insureds/persons from any further financial obligation for the health care services rendered. Health care providers and/or health care professionals shall be deemed to have released, discharged and waived any and all rights to take any legal action or redress, either in person or via transfer, assignment or subrogation, to collect any unpaid amounts from insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs or any or all other health insurance entities. Any violation by health care providers and/or health care professionals of this provision may be deemed an unfair trade practice under LSA R.S. 22:250.41 *et seq.* and may be referred to the Louisiana Attorney General. Specifically, as enumerated in LSA R.S. 22:250.47, such acts may constitute an attempt to collect an amount in excess of the specified reimbursement rate set forth in §3717.A(1) or (2), and the Louisiana Attorney General may pursue remedies as provided for in LSA R.S. 51:1401 *et seq.*

4. With regard to all payments made pursuant to §3717, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities should first determine whether the health care provider and/or health care professional is contracted or non-participating in order to establish the appropriate fifty (50%) percent reimbursement rate, and should subsequently apply the appropriate co-payments, deductibles and/or co-insurance in determining the net amount of the fifty (50%) percent reimbursement rate to be paid. Notwithstanding this provision, health care providers and/or health care professionals shall not collect from insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs or any or all other health insurance entities any amount in excess of fifty (50%) percent of the contracted rate or non-participating rate as set forth in §3717.A(1) or (2). Once insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities make the payment set forth in §3717.A(1) or (2), that payment shall be the full extent of the obligation of the insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities for the health care services rendered during the State of Emergency unless the underlying premium is subsequently paid. If the underlying premium is subsequently paid, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall re-adjudicate and reprocess claims in accordance with §3705.A and the prompt pay laws pursuant to LSA R.S. 22:250.31 *et seq.* and LSA R.S. 22:250.51 *et seq.* Such prompt payment provisions are reinstated from the lifting of Emergency Rule 20.

5. As to health care providers and/or health care professionals who have business operation(s) within the three (3) primary parishes and who rendered health care services to insureds/persons as defined in §3701 within the three (3) primary parishes, §3717 shall be applied as follows: Upon confirmation from insureds/persons and/or policyholders that a

premium will not be paid, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall be required to pay according to the prompt pay laws set forth in LSA R.S. 22:250.31 *et seq*. and LSA R.S. 22:250.51 *et seq*. and pursuant to the policy provisions. These provisions are reinstated from the lifting of Emergency Rule 20. All claims pended for nonpayment of premium shall be paid at no less than the reimbursement rate set forth in §3717.A(1) or (2), depending on whether or not health care providers and/or health care professionals are contracted or non-participating. Additionally, if health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities have received said confirmation prior to the issuance of Directive 189, then health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall pay such aforementioned claims in no more than thirty (30) days from the date of the issuance of Directive 189. If said confirmation is received subsequent to the issuance of Directive 189, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall pay such aforementioned claims in no less than thirty (30) days from receipt of said confirmation.

6. As to all other health care providers and/or health care professionals who have business operations outside the three (3) primary parishes and who rendered health care services to insureds/persons as defined in §3701 outside the three (3) primary parishes, §3717 shall be applied as follows: When it is ultimately determined that the premium for the health insurance policy will not be paid and the policy is cancelled for non-payment of premium, then all claims pended for nonpayment of premium shall be paid according to the prompt pay laws set forth in LSA R.S. 22:250.31 *et seq*., LSA R.S. 22:250.51 *et seq*., and pursuant to the policy. These provisions shall be reinstated upon the lifting of Emergency Rule 20. All claims pended for nonpayment of premium shall be paid at no less than the reimbursement rate set forth in §3717.A(1) or (2), depending on whether or not health care providers and/or health care professionals are contracted or non-participating. If the underlying premium for the health insurance policy has not been paid as of the date of the expiration or lifting of the State of Emergency, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall promptly pay all such aforementioned claims in accordance with R.S. 22:250.31, *et seq* and LSA R.S. 22:250.51 *et seq.*

7. The intent of §3717 is that claims for covered services – both elective and non-elective – must be reimbursed at fifty (50%) percent of the applicable rate. The intent of §3717.A(3) is that such claims for elective and non-elective services are subject to LSA R.S. 22:3077 *et seq*. Emergency Rule 20 and Directive 189 shall not be applicable to emergency health care services for an emergency medical condition as defined in LSA R.S. 22:657 and shall not be subject to medical necessity review, but shall be subject to the reimbursement set forth in §3117.A.1 or .A.2 when there has been a non-payment of premium.

8. Section 3717.A(4) states that health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities are prohibited from taking any action against: (A) insureds/persons or policyholders for any unpaid premium after the cancellation of the policy of health insurance for non-payment of the premium; or (B) health care providers and/or health care professionals for any amounts paid pursuant to §3717.A(1) or (2) with regard to covered claims for health care services rendered during the State of Emergency. Furthermore, as it relates to insureds/persons, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other

health insurance entities, health care providers and/or health care professionals shall only be entitled to collect an amount that equals fifty (50%) percent of the contracted rate or non-participating rate as set forth in §3717.A(1) or (2). Additionally, co-payments, deductibles for that health care service, and co-insurance shall be applied towards the amount set forth in §3717.A(1) or (2). Any amounts collected by health care providers and/or health care professionals from insureds/persons or health insurance issuers HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities in excess of the fifty (50%) percent amount established in §3717.A(1) or (2) shall be considered "balance billing" against insureds/persons and shall be prohibited, except for applicable co-payments, deductibles and co-insurance for that specific health care service. Health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities may, on behalf of insureds/persons, recoup such excess amount from health care providers and/or health care professionals and the amount recouped shall be reimbursed to the insureds/persons.

9. In the event health care providers and/or health care professionals obtain payments of claims for covered health care services from collateral sources, then to the extent said payments exceed the contracted rate or non-participating rate health care providers and/or health care professionals shall return the amount in excess of the contracted rate or non-participating rate to insureds/persons and/or health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities. Health care providers and/or health care professionals shall not be entitled to receive more than one-hundred (100%) percent of the contracted rate or non-participating rate for covered health care services rendered.

10. §3719 suspends physician credentialing with regard to licensed physicians. The purpose and intent of §3719 is to suspend the requirement that health care providers and/or health care professionals must be licensed in Louisiana. To the extent that health care services are rendered to insureds/persons as defined in §3701 and health care providers and/or health care professionals hold a license from another state, and said license has not been restricted or revoked in that state, then said health care providers and/or health care professionals shall be deemed to have complied with the credentialing requirements in Louisiana for the purpose of being entitled to file claims for health care services. This suspension is intended to include not only licensed physicians but licensed health care providers and/or licensed health care professionals who render medical services to insureds from the parishes referenced in §3701.

11. §3735 states: "The provisions of Emergency Rule 20 shall not prevent health insurance issuers or HMOs from canceling or terminating an insured based solely on fraud or material misrepresentation on the part of the insured." The purpose and intent of this provision is that health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health entities have no obligation to pay fraudulent claims submitted by health care providers and/or health care professionals. As such, claims that are determined to be fraudulent may be the subject of retrospective denial and recoupment by health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health entities, and may also be the subject of a referral by the Commissioner to the appropriate civil or criminal authorities.

12. Health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall track the amount of claim(s) that are applicable to the fulfillment of the

insureds'/persons' co-payments, deductibles and co-insurance. Health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities shall transmit such information to insureds/persons in an explanation of benefits indicating what claim(s) have been applied to the co-payment, deductible, and/or co-insurance and when insureds/persons have met such co-payments, deductible, and/or co-insurance. Furthermore, health care providers and/or health care professionals shall submit claims for health care services rendered to insureds/persons, as defined in §3701, regardless of whether payments are received from insureds/persons or not. If insureds/persons believe that an overpayment of a co-payment, deductibles, and/or co-insurance has occurred, said insureds/persons shall contact the respective health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities or the Louisiana Department of Insurance.

13. Health care providers and/or health care professionals shall submit claims to health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities for services rendered to insureds/persons. Upon adjudication of such claims, health insurance issuers, HMOs, PPOs, MCOs, TPAs or other health insurance entities shall maintain records of the application of co-payments, deductibles and/or co-insurance and shall include such information in notices to the insureds/persons, health care providers and health care professionals in the form of Explanation of Benefits, Explanation of Payments, Remittance Advice, or similar communication. Health insurance issuers, HMOs, PPOs, MCOs, TPAs or other health insurance entities shall have the right to recoup such amounts on behalf of the insureds/persons and shall reimburse the insureds/persons.

14. In those situations governed by §3717, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities shall be required to provide to insureds/persons an explanation of benefits for all health care services rendered during the State of Emergency.

15. If health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities make a presumptive payment of health care claims at the fifty (50%) percent rate established in §3717.A (1) or (2), and subsequently receive the payment of the premium prior to cancellation of the health insurance policy, then health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities shall re-adjudicate and/or re-process said claims and pay health care providers and/or health care professionals in accordance with the provisions of §3705.A and the shall be required to pay pursuant to the prompt pay provisions of LSA R.S. 22:250.31 *et seq.* and LSA R.S. 22:250.51 *et seq.*

16. Any and all health insurance issuers, HMOs, PPOs, MCOs, TPAs and any and all other health insurance entities may voluntarily pay an amount in excess of the reimbursement rate established in §3717.A(1) or (2). Health care providers and/or health care professionals who accept the voluntary payment and submit evidence of such to the Louisiana Department of Insurance may not be referred to the Attorney General.

17. If, prior to August 26, 2005, insureds/persons and/or policyholders had prepaid the premium for a health insurance policy for a policy term that expires on or after January 1, 2006, said health insurance policy shall be considered in full force and effect and any and all claims

handled pursuant to said health insurance policy shall be exempt from Emergency Rule 20 and Directive 189.

18. If the applicable premium for the policy of health insurance is paid at any time prior to the termination of Emergency Rule 20 or applicable grace period, then as of the date the premium payment is received by the health insurance issuer, HMO, PPO, MCO, TPA or any and all other health insurance entities, the adjudication, processing and payment of all claims shall comply with the applicable prompt pay laws set forth in R.S. 22:250.31, *et seq.* and R.S. 22:250.51, *et seq.*

19. Within thirty (30) days after the expiration of the applicable grace period pursuant to the policy, health insurance issuers, HMOs, PPOs, MCOs, TPAs and any or all other health insurance entities shall send to any and all health care providers and/or health care professionals who have filed a claim with respect to insureds/persons a notice in the form of an Explanation of Benefits, Explanation of Payments, Remittance Advice, or similar communication indicating that the insureds'/persons' coverage no longer exists.

20. Emergency Rule 20 and Directive 189 shall be applicable to claims for health care services rendered to insureds/persons defined in §3701 during the period of the State of Emergency relating to Hurricane Rita and its aftermath.

21. For clarification purposes, in §3711, renewals between September 20, 2005 and January 1, 2006 are hereby "extended", not "suspended" as stated on line 7.

You are hereby directed to immediately bring your business practices into compliance with the unequivocal purpose and intent of original Emergency Rule 20, and any subsequent amendment of Emergency Rule 20. Please be governed accordingly.

Baton Rouge, Louisiana this 1st day of November, 2005.

BY: 

J. ROBERT WOOLEY
COMMISSIONER OF INSURANCE